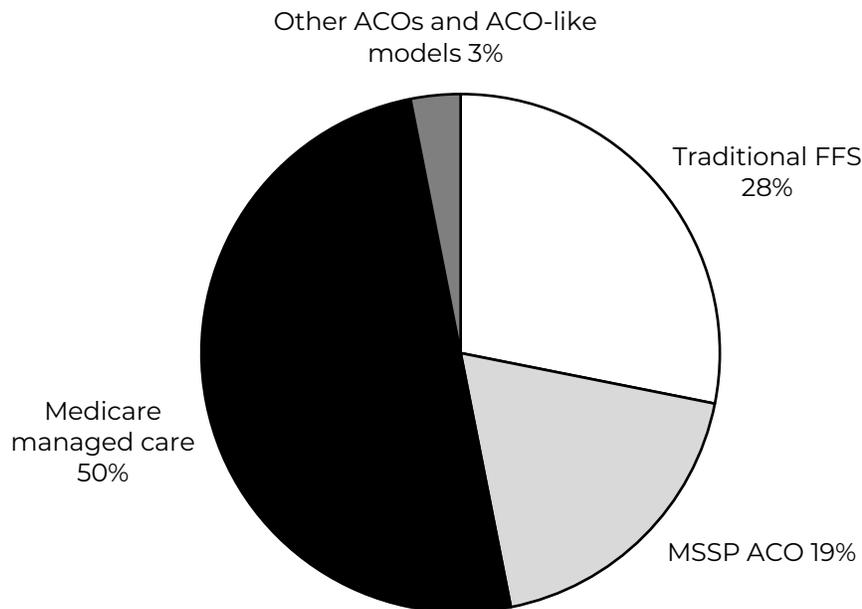


SECTION

5

**Alternative
payment models**

Chart 5-1. Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2022

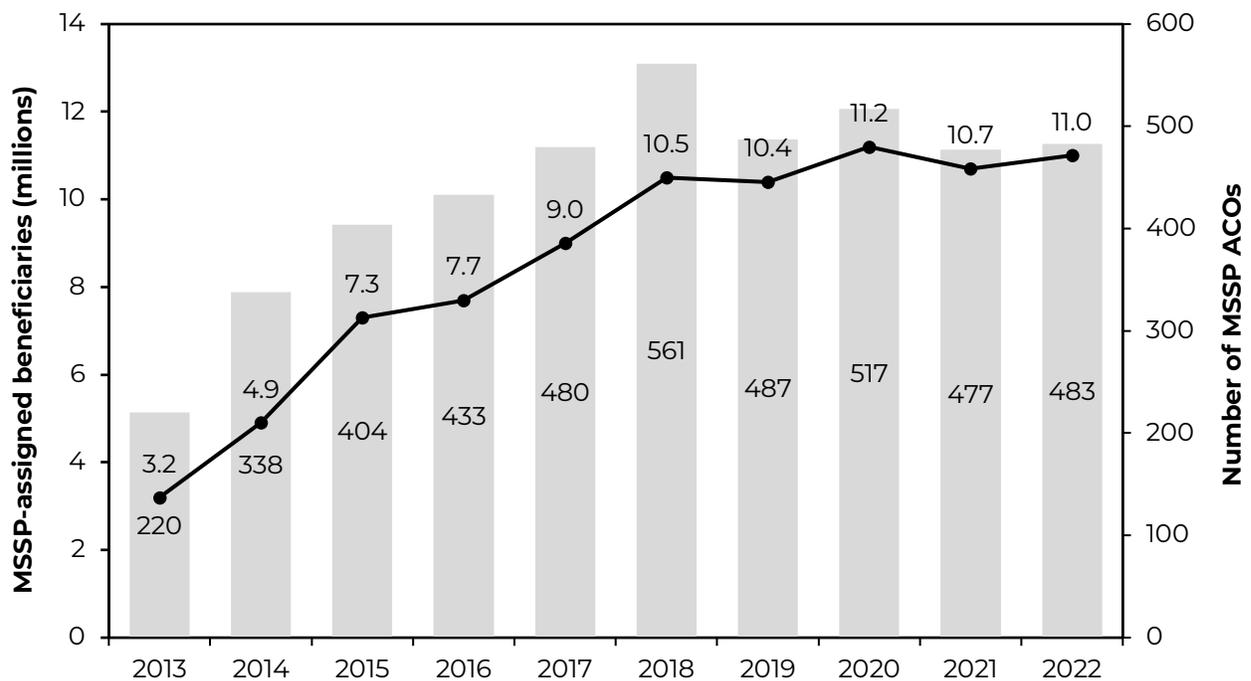


Note: ACO (accountable care organization), FFS (fee-for-service), MSSP (Medicare Shared Savings Program). This chart includes only beneficiaries enrolled in both Part A and Part B in January 2022. Both Part A and Part B coverage is necessary for either Medicare Advantage enrollment or ACO assignment. In general, Medicare managed care plans include Medicare Advantage plans as well as cost-reimbursed plans and Medicare-Medicaid demonstration plans. Other ACOs and ACO-like models include the Global and Professional Direct Contracting (GPDC) Model, the Maryland Total Cost of Care (TCOC) Model, and the Vermont All-Payer ACO. In the Maryland TCOC Model, all FFS beneficiaries are assigned to a hospital, and each hospital is responsible for all Part A and Part B spending for all Medicare beneficiaries in its market. This system creates ACO-like incentives for the hospital and qualifies physicians affiliated with those hospitals for the Medicare Access and CHIP Reauthorization Act (MACRA) bonus payments for participation in eligible alternative payment models.

Source: CMS January 2022 enrollment data, CMS Shared Savings Program January 2022 Fast Facts, CMS GPDC 2021 summary performance and 2022 GPDC participant list, CMS ACO Next Generation 2020 performance data for Next Generation ACOs entering GPDC in 2022, and State of Vermont Green Mountain Care Board 2021 alignment report.

- Among the 58.6 million Medicare beneficiaries with both Part A and Part B coverage in 2022, approximately three-fourths (72 percent) are in Medicare managed care (Medicare Advantage or other private plans) or ACO models.
- The Medicare Shared Savings Program—a permanent ACO model established through the Affordable Care Act of 2010—accounts for most of the beneficiaries assigned to ACO or ACO-like payment models.
- Only 28 percent of Medicare beneficiaries with both Part A and Part B coverage are now in traditional FFS Medicare—a share that has declined in recent years.
- Even among the share of beneficiaries in traditional FFS, some beneficiaries may be assigned to other alternative payments models such as the Bundled Payments for Care Improvement Advanced Model or the Primary Care First Model.

Chart 5-2. The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 and then leveled off

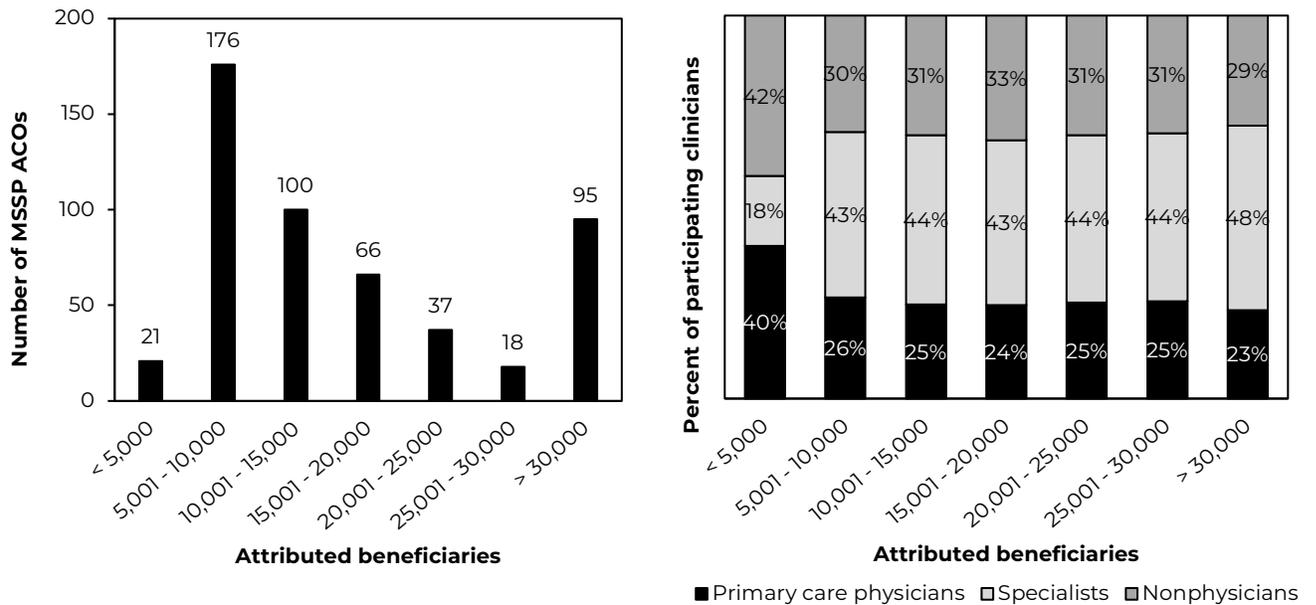


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). Numbers are as of January in each year. In 2019, MSSP ACOs were allowed to join the program in July. Those ACOs and the beneficiaries assigned to them were therefore not in the program as of January 2019 and so are not included in the 2019 counts on this chart. As of July 2019, there were 518 MSSP ACOs and 10.9 million beneficiaries assigned to them (data not shown). In 2021, new MSSP ACOs were not allowed to join the program due to the coronavirus pandemic, though ACOs were still allowed to exit the program.

Source: CMS Shared Savings Program January 2022 Fast Facts.

- The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has leveled off in recent years. In 2022, 19 percent of beneficiaries enrolled in both Part A and Part B were assigned to an MSSP ACO (see Chart 5-1).
- The number of ACOs peaked at 561 in 2018 and then declined to 487 in 2019. Growth in the number of ACOs was relatively flat between 2019 and 2022.
- CMS finalized changes to MSSP at the end of 2018 that included (1) requiring ACOs to transition toward greater levels of financial risk and (2) using regional spending as a component of all ACO benchmarks (the spending levels used to measure an ACO's financial performance). These changes coincided with some ACOs dropping out of the program and fewer new ACOs joining.
- While the number of ACOs and assigned beneficiaries has leveled off in recent years, the number of beneficiaries per ACO continues to increase (data not shown).

Chart 5-3. Distribution of ACOs and types of providers participating in MSSP, by number of attributed beneficiaries, 2020

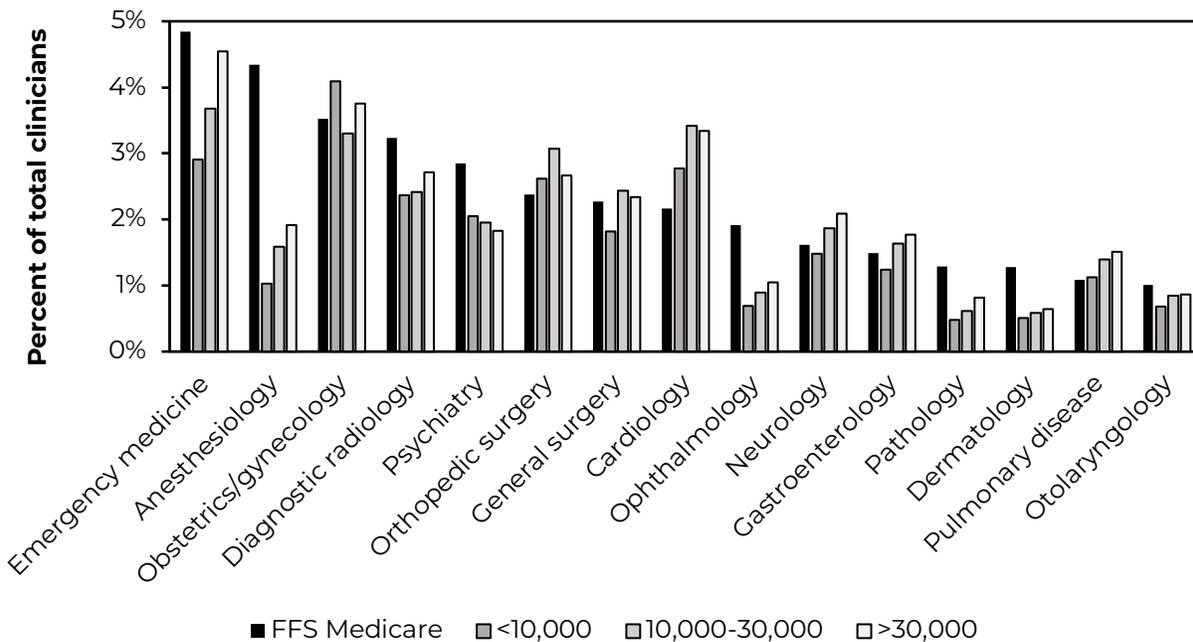


Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program). As of January 2020, there were 517 MSSP ACOs, but the chart includes only the 513 ACOs that did not drop out of the program prior to July 2020. "Nonphysician" clinicians include nurse practitioners, physician assistants, and clinical nurse specialists.

Source: Shared Savings Program Accountable Care Organizations public use files.

- Of 513 MSSP ACOs, more than half (58 percent) have 15,000 or fewer attributed beneficiaries. Less than 19 percent of MSSP ACOs have 30,000 or more attributed beneficiaries.
- MSSP ACOs usually have a combination of primary care physicians, specialists, and nonphysician practitioners; the mix of these practitioners is relatively similar across size categories. On average, 24 percent of clinicians participating in an MSSP ACO are primary care physicians, while 46 percent are specialists and 30 percent are nonphysician practitioners (data not shown).
- Primary care physicians comprise at least half of all participating clinicians in 60 (12 percent) MSSP ACOs, while specialists comprise more than half of all clinicians in 103 (20 percent) of MSSP ACOs (data not shown).

Chart 5-4. Participation by select specialists in MSSP ACOs, by number of attributed beneficiaries, 2018

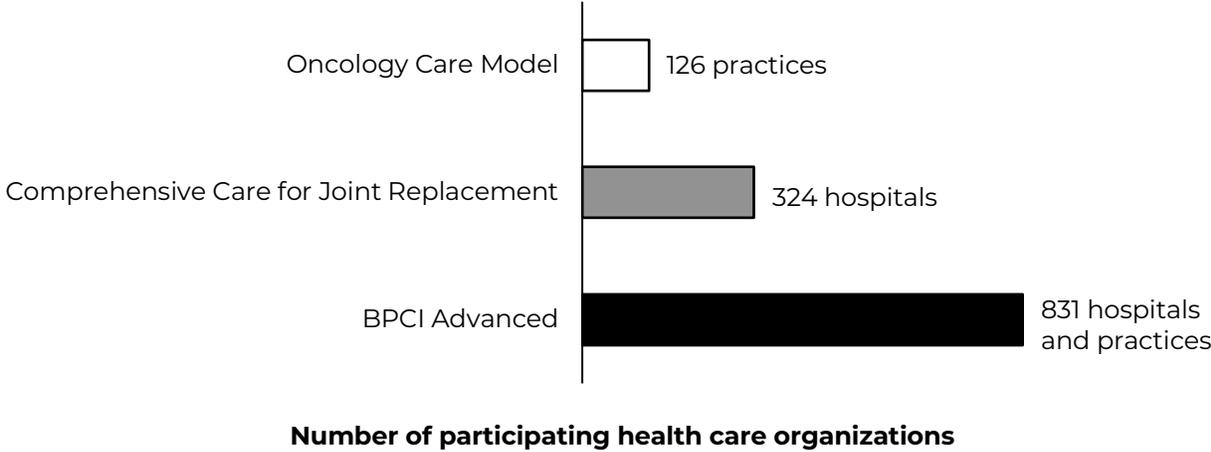


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), FFS (fee-for-service). “Total clinicians” includes all physicians, nurse practitioners, physician assistants, and clinical nurse specialists. This chart focuses on non–primary care physician specialties.

Source: Shared Savings Program Accountable Care Organizations public use files and research identifiable files; Carrier Standard Analytic File for 100 percent of Medicare beneficiaries.

- ACOs by design are oriented around primary care, but specialists can and do participate in these models. Most MSSP ACOs have a mix of physicians among various clinical specialties.
- Specialists’ participation in ACOs relative to their share of all clinicians varies by specialty. For example, cardiologists comprise about 2 percent of all clinicians participating in FFS Medicare, but a larger share of clinicians participating in ACOs. By contrast, specialties such as anesthesiology and ophthalmology are underrepresented in ACOs relative to their share of all FFS clinicians.
- The portion of participating specialist physicians varies greatly across ACOs. For example, cardiologists account for a little more than 3 percent of all MSSP ACO physicians, but they comprise anywhere from 0 percent to 20 percent of clinicians in any individual ACO (data not shown).
- The portion of specialists as a share of all clinicians who participate in MSSP tends to be somewhat higher among larger ACOs (as measured by the number of attributed beneficiaries in each ACO). For example, the share of clinicians who specialize in emergency medicine is 2.9 percent in smaller ACOs, 3.7 percent in midsize ACOs, and 4.5 percent in the largest ACOs.
- Many specialties account for a larger share of clinicians in larger ACOs. This finding may reflect smaller ACOs being more often composed of independent physician practices with relatively fewer specialists, while larger ACOs are often affiliated with hospitals or health systems that have a broader range of specialists.

Chart 5-5. BPCI Advanced is Medicare’s largest episode-based payment model, 2022

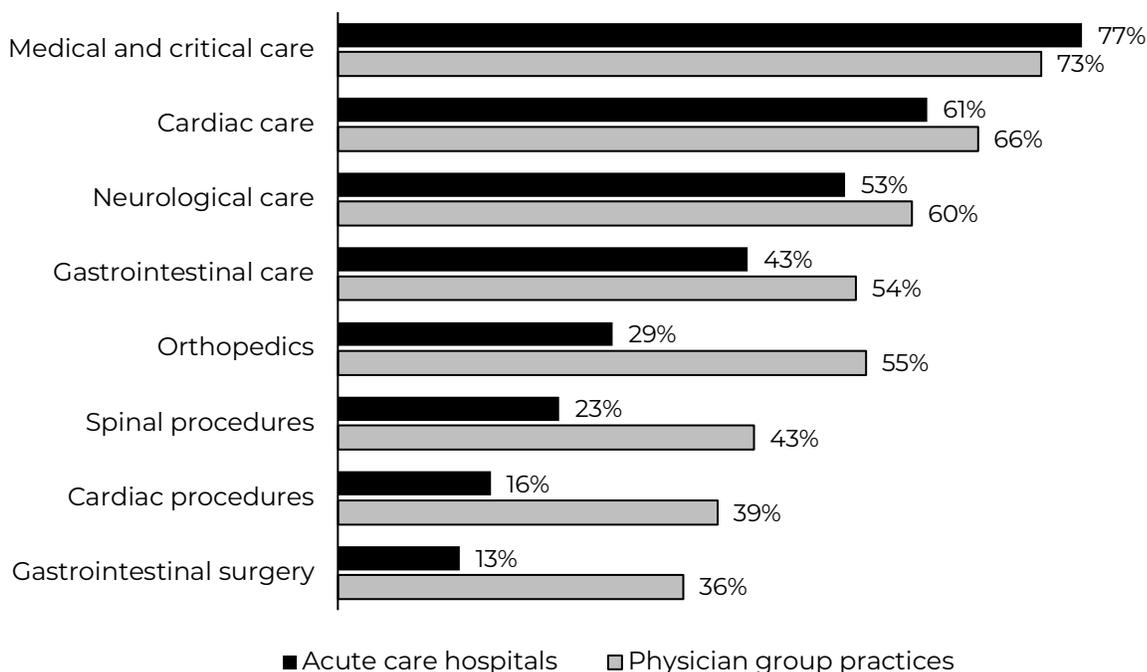


Note: BPCI (Bundled Payments for Care Improvement).

Source: CMS’s Oncology Care Model website (<https://innovation.cms.gov/innovation-models/oncology-care>); Comprehensive Care for Joint Replacement website (<https://innovation.cms.gov/innovation-models/cjr>); information on BPCI Advanced participants: CMS’s Where Innovation Is Happening website (<https://innovation.cms.gov/innovation-models/bpci-advanced>); 2020 CMMI Report to the Congress (<https://innovation.cms.gov/data-and-reports/2021/rtc-2020>).

- Medicare fee-for-service (FFS) providers can participate in episode-based payment models, and roughly one million Medicare beneficiaries have been attributed to at least one of these models.
- Episode-based payment models give health care providers a spending target for most types of care provided during a clinical episode (e.g., six months of chemotherapy or an inpatient admission or outpatient procedure plus most other care provided in the subsequent 90 days). If total spending is less than the target, Medicare pays providers a bonus; if total spending is more than the target, Medicare recoups money from providers.
- Within FFS Medicare, the episode-based payment model with broadest participation is the BPCI Advanced Model, with 831 participating hospitals and practices (435 acute care hospitals and 396 physician group practices participate as episode initiators).

Chart 5-6. Share of BPCI Advanced episode initiators accepting responsibility for each clinical episode group, 2022

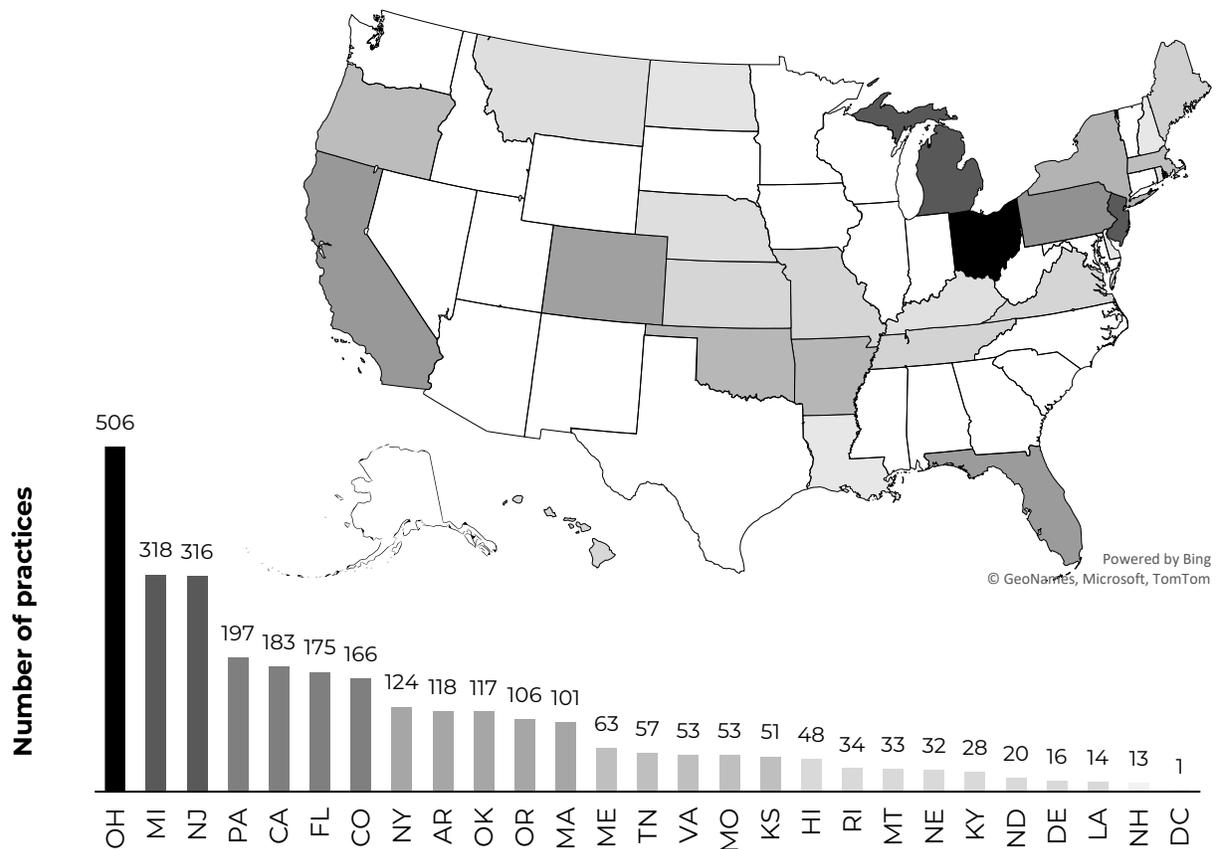


Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple clinical-episode service-line groups. The denominators for each group are 435 acute care hospital and 396 physician group practice episode initiators in 2022.

Source: List of clinical-episode service-line groups each BPCI Advanced participating episode initiator agreed to take financial responsibility for in Model Year 5 (2022) downloaded from CMS’s BPCI Advanced webpage (<https://innovation.cms.gov/innovation-models/bpci-advanced>).

- BPCI Advanced covers dozens of types of inpatient and outpatient clinical episodes, which are aggregated into eight clinical-episode service-line groups (e.g., the cardiac care group includes acute myocardial infarction, cardiac arrhythmia, and congestive heart failure). Participating hospitals and physician practices select the service-line groups for which they will be financially responsible under the model.
- About three-quarters of hospital and physician practices initiate episodes within the medical and critical care service-line group, while only 13% of hospitals and 36% of physician practices opt to initiate episodes under the gastrointestinal surgery service-line group.
- More than 70 percent of BPCI Advanced episode initiators accept episode-based payments for fewer than five clinical-episode service-line groups. Twenty-two percent accept episode-based payments for only one clinical-episode service-line group (data not shown).

Chart 5-7. Almost 3,000 practices are testing the Primary Care First model, 2022

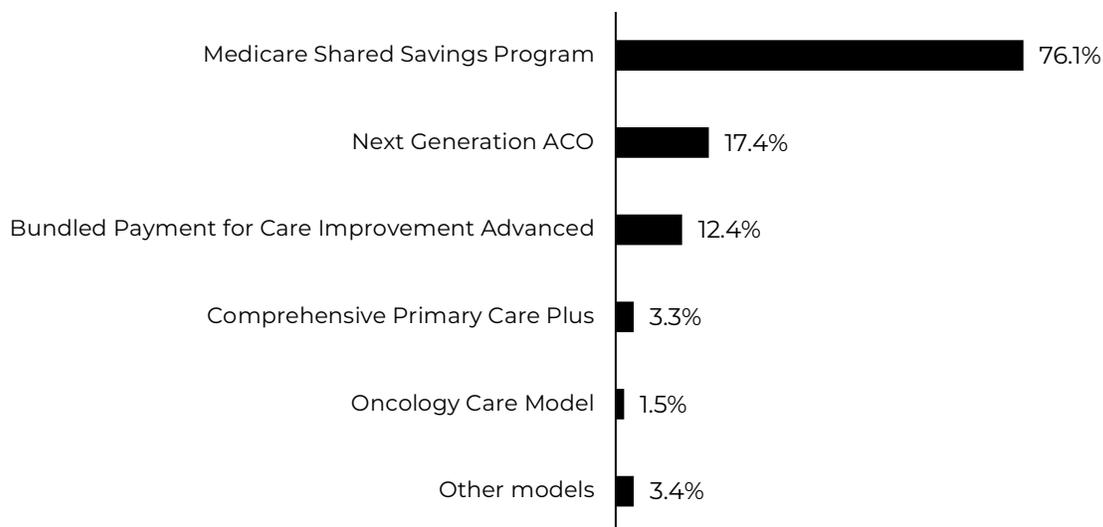


Note: Primary Care First is an advanced alternative payment model that CMS began testing with the first cohort in 2021 and the second cohort in 2022. Primary Care First is a multipayer model, with some Medicaid and private insurers voluntarily paying similar fees for their enrollees.

Source: CMS's list of Primary Care First practices (<https://innovation.cms.gov/innovation-models/primary-care-first-model-options>).

- CMS's Primary Care First is an advanced alternative payment model that has about 3,000 participating practices in 26 states and the District of Columbia. The model aims to strengthen primary care by testing alternative ways of paying participating providers of primary care services. These payments are intended to support enhanced, coordinated care management and assist with care delivery transformation.
- Participating practices receive a risk-adjusted per beneficiary per month care management fee, plus a flat primary care visit fee instead of fee-for-service payments for certain primary care services. These payments are subject to adjustments determined by each practice's performance on specified quality and utilization measures.

Chart 5-8. About 75 percent of the clinicians who qualified for a 5 percent A-APM bonus in 2022 were in the Medicare Shared Savings Program



Note: A-APM (advanced alternative payment model), ACO (accountable care organization). Clinicians' 2020 A-APM participation determines their 2022 bonuses. Shares do not sum to 100 percent because clinicians can participate in more than one A-APM simultaneously. To qualify for the A-APM bonus in 2022, clinicians had to receive 50 percent of their professional services payments or provide 35 percent of their patients with professional services through an A-APM in 2020. The A-APM bonus is equal to 5 percent of a clinician's professional services payments from Medicare (not including cost sharing paid by beneficiaries). "Other models" includes the Maryland Total Cost of Care Model, Comprehensive Care for Joint Replacement Model, Comprehensive ESRD (End-Stage Renal Disease) Care Model, and Vermont ACO model. For the payment models shown, only those model tracks that require clinicians to take on some financial risk qualify as A-APMs (e.g., physicians participating in Track 1 of the Medicare Shared Savings Program did not qualify for A-APM bonuses because Track 1 involved no financial risk for participants).

Source: CMS data on clinicians who qualified for the 5 percent bonus in 2022 based on clinicians' 2020 model participation.

- The payment models that CMS has designated as A-APMs place health care providers at some financial risk for Medicare spending while expecting them to meet quality goals for a defined patient population. Clinicians who participate in A-APMs qualify for bonuses equal to 5 percent of their professional services payments from Medicare. These bonus payments are available from 2019 to 2024.
- In 2022, nearly 237,000 clinicians nationwide qualified for the A-APM bonus (based on 2020 A-APM participation) out of about 1.3 million who billed the Medicare physician fee schedule. About 93 percent of these clinicians participated in ACOs, which give clinicians an opportunity to earn shared savings payments from Medicare if they lower health care spending while meeting care quality standards (data not shown).
- Among clinicians who qualified for an A-APM bonus in 2022, 38 percent were specialists, 23 percent were primary care physicians, and 38 percent were nonphysician practitioners (data not shown).